STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN OF CONRECTION		IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL092-319	B. WING			C 03/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BRADLE	YHOME		LLY ROAD R, NC 27529			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	A complaint survey was completed on June 3, 2025. The complaint was substantiated (Intake #NC00229287). Deficiencies were cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.					
	This facility is licensed for 6 and has a current census of 2. The survey sample consisted of audits of 2 current clients.					
	sister facility will be	identified in this report. The identified as sister facility A. ified using the letter of the rical identifier.				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified of this Rule shall be	502 STAFF os above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to ond to individualized client				
	(b) A minimum of or present at all times premises, except w habilitation plan doo capable of remainin	one staff member shall be when any adult client is on the when the client's treatment or cuments that the client is ng in the home or community . The plan shall be reviewed	9			
	as needed but not l the client continues	ess than annually to ensure to be capable of remaining in unity without supervision for				
	(c) Staff shall be p following client-staf child or adolescent	resent in a facility in the f ratios when more than one				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		СОМ	E SURVEY PLETED
		MHL092-319	B. WING			C 03/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
BRADLE	YHOME		LLY ROAD 8, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 290	REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.					
	interview the facility	et as evidenced by: on, record review and rfailed to ensure a minimum o vas present at all times. The	f			
	 Admitted 9/18/9 Diagnoses of S 	chizophrenia, Paranoid Type, roesophageal Reflux Disease,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-319	B. WING			C 06/03/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
BRADLE	YHOME		LLY ROAD R, NC 27529				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
V 290	Continued From pa	ge 2	V 290				
	 Admitted 8/13// Diagnoses of M Mood Adjustment, I Impediment/Disturt Colostomy and Hyp Observation at 10:5 revealed: There were no Observation at 11:3 facility A revealed: Clients #1 and # Stored in a separate located in the facilitit Client #2 had 2 	lajor Depressive Disorder, Psychosis, Speech bances, Traumatic Brain Injury					
	 Had been at sist because former standing ago Client #4A movand he slept in clier He brought a client and he slept in clier 	5 client #1 reported: ster facility A since 5/18/25 iff (FS) #3 left the facility a fev red into client #5A's bedroom nt #4A's bedroom hange of clothes, his radio and m when he was moved to					
	 Had been at sis because FS #3 more He brought his him when he was n Didn't know how facility A 	5 client #2 reported: ster facility A for two nights ved out of state two nights ago clothes and medications with noved to sister facility A w long he was staying at sister nt #3A's bedroom while client					

Division of Health Service I STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
		MHL092-319			06/	03/2025
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST LLY ROAD	ATE, ZIP CODE		
BRADLE	EY HOME		R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 290	Continued From pa	ge 3	V 290			
	#3A was out of town	ı				
	 Interview on 5/21/25 client #4A reported: Clients #1 and #2 arrived at sister facility A a few days ago She was sharing a bedroom with client #5A and client #1 was sleeping in her bedroom 					
	Interview on 5/21/25 client #5A reported: - Clients #1 and #2 hadn't been staying at sister facility A for "too long" - She and client #4A were sharing her bedroom for "a couple of nights"		n			
	Interview on 5/21/25 client #6B reported: - Clients #1 and #2 came to sister facility A two or three days ago					
	 Clients #1 and a facility A for "half a g He thought client 	5 client #7B reported: #2 had been staying in sister /ear" nt #2 shared a bedroom with e honest I'm not sure"				
	- Clients #1 and two nights ago beca staff	5 staff #A1 reported: #2 moved to sister facility A ause the facility didn't have a				
	weren't staying at s - Clients #1 and two days worth of c	impression" clients #1 and #2 ister facility A "for too long" #2 came to sister facility A with lothes d clients #1 and #2 back to the	ו			
	facility to shower ar - Client #1 was s bedroom while clier					
	bedroom and client with client #5A	#4A was sharing a bedroom wner was "in the process of				

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-319	B. WING			C 03/2025
IAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
BRADLE	EY HOME		LY ROAD 2, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 290	hiring a new staff" f Director/Owner told staff hired by Mond Interview on 5/21/2 - Clients #1 and facility A because s - The "set up" wi facility A was "temp situation" because coverage for the fa - Planned for the facility once she hir - Was in the prod	for the facility and the I her that she "hoped to have a ay (5/26/25)" 5 the Director/Owner reported: #2 were staying at sister he terminated FS #3 th the clients sleeping at sister orary" and an "emergency she didn't have any staff cility e clients to move back to the				